

## **CHAPTER VII – CERTIFICATION, RECERTIFICATION AND INDIVIDUAL SERVICE PLAN REVISIONS**

After the participant's initial certification of eligibility, each Waiver requires annual recertification to ensure that the participant remains eligible for the Waiver. The recertification process for each Waiver, described in this chapter, accomplishes this objective and documents the results.

### **7.01 Certification and Annual Recertification for CIP 1A and CIP 1B**

The recertification process for CIP 1A and CIP 1B is done on a 3-year cycle. It begins once the initial certification of eligibility is complete. BDDS attaches a copy of the last page of the Individual Service Plan (DDES-Form 445 or the DDES 445 BDDS Revision 9/2003) to the initial approval letter, which is sent to the county. This page specifies the month in which the recertification must be completed.

A description of the content and sequence of the recertification process for years 1-3 following the initial eligibility determination follows:

#### **A. Level of Care (LOC) Determination**

Each year following the initial certification of eligibility, a Qualified Mental Retardation Professional (QMRP) (See Appendix C for the definition of QMRP) must review the entire Level of Care Determination Form (LOC 2256/2256a). The QMRP decides if the level of care remains the same and if the person continues to be functionally eligible. If the level of care remains the same, the QMRP documents this by signing the final page of the Form DDES 445 and submitting it together with a new Individual Service Plan to BDDS central Office.

If the QMRP believes that the participant is no longer at an eligible level of care for CIP1 A or CIP 1B, the QMRP must complete a new level of care determination. Form 2256/2256a is completed and sent to Bureau of Quality Assurance staff for review and action. The new rated form is then sent to the BDDS Central Office contact.

A second option for the recertification process is available for those Support and Service Coordinators or other designated county staff who have completed the training on the Long Term Care Functional Screen (LTCFS). These staff may use the LTCFS to establish the person's level of care. The Support and Service Coordinator or designated staff must complete the form each year. If there is no change in the level of care, the result page showing continued level of care is placed in the participant's file and need not be sent to BDDS. The form must be made available for inspection during audits or monitoring reviews if requested. If the LTCFS reveals a change in the level of care, documentation of that change must be sent to the BDDS Central Office contact.

Effective January 1, 2005, DDES Forms 2256 and 2256a will no longer be accepted for determining Level of Care. All counties will be required to use the

Long Term Care Functional Screen for initial eligibility determination and recertification.

B. Individual Service Plan

Each year following the initial eligibility certification, the county's Support and Service Coordinator or other designated staff must complete a new Individual Service Plan (DDES Form 445 or BDDS Revision) or an approved substitute. The participant/ guardian should play a significant part in completing the new Individual Service Plan. This form includes a last page titled: "Annual Recertification for CIP 1". The completed form is sent to the BDDS Central Office contact. The last page must include all required signatures.

C. Medicaid Waiver Eligibility and Cost-Sharing Worksheet/ CARES Screen

Each year following the initial certification the county must complete a new Medicaid Waiver Eligibility and Cost-Sharing Worksheet (DDES Form-919) or CARES Screen. This form must be maintained by the county in an easily accessed location and be made available for inspection during individual monitoring reviews or program or provider audits. The form need not be sent to BDDS.

D. BDDS Recertification Acknowledgement/ Approval Letter

Following receipt and approval of recertification documents by BDDS, a letter will be sent to the county acknowledging receipt of the required information and confirming the participant's continued eligibility for the Waiver program. The letter also contains the date (month) the next recertification is due. Although items (A) and (C) above are not sent to BDDS each year, they must be kept current and available at the county in an easily accessed location for individual specific reviews and program or provider audits.

Recertification Requirements at the End of each 3-Year Cycle

Unless the county is using the LTCFS, a new Level of Care determination is required at the end of each three-year cycle. When the new LOC is required, the county must complete and send a new LOC Form to BQA for rating. When BQA completes its rating, the rated LOC must be sent to BDDS.

Those counties using the LTCFS must complete the screen annually on or before the anniversary date and send the rating page of the LTCFS to BDDS every three years. The county must also send the current cost-sharing worksheet or Cares screen and the most current Individual service plan including the signature page to BDDS. This recertification process must be accomplished during the same month, not more than one year later than when the previous recertification was completed. For example, if the Year 3 recertification occurred on October 15, 2004, the required recertification must occur prior to October 31 of 2005.

Whenever possible, the packet should be submitted to BDDS during the recertification month. Once the staff in BDDS have reviewed the packet, BDDS will return a copy of the annual recertification for CIP (page 4, ISP) along with a recertification letter. The participant will then begin a new recertification and BDDS will initiate a new 3-year cycle.

All counties will be required to use the Long Term Care Functional Screen for initial certifications and recertifications as of January 1, 2005. Effective that date, all materials in this Manual referring to the BQA-rated LOC cannot be used to establish eligibility.

## **7.02 Annual Certification/ Recertification for BIW**

After the initial determination of eligibility, annual recertification is required for the BI Waiver to ensure that participants remain eligible for the BI Waiver. The recertification process for the BIW accomplishes this and documents the results. Participants in the Brian Injury Waiver are required to complete the BIW recertification process annually. Recertification is required the same month as the participant's Waiver start date.

The county must complete and send the following information in the recertification packet to BDDS:

### 1. A new Level of Care form, DDES Forms 2256 and 2256a

The DDES Forms 2256 and 2256a must be filled out, and signed by a physician or registered nurse. The form must be sent in to BDDS without a LOC rating because the actual rating of LOC in the BI Waiver is done by BDDS. BDDS will determine the rating upon receipt of the recertification packet.

The option of using the Long Term Care Functional Screen (LTCFS) is being developed but is not currently available for BIW applicants or participants. It is anticipated that the BDDS rating process will be discontinued when the LTCFS process is validated and operational for people using this Waiver.

### 2. A New Individual Service Plan (DDES-445, BDDS Revision)

An updated Individual Service Plan must be included with the annual recertification packet. The plan may call for changes to the type and amount of services or may call for providing the same services and supports but must be submitted as a new document with a new signature page.

### 3. An Eligibility Cost Sharing Worksheet (DDES-919, Revised 3/02) or CARESScreen

As with CIP 1, all forms must be dated no later than the same month the recertification is due. When the recertification documents are received and approved by BDDS, a letter will be sent to the county with an assigned rating.

The letter will also acknowledge the person's continued participation in the program and indicate the month the next recertification is due.

### **7.03 Certification and Recertification for CLTS Waivers**

**(RESERVED)**

### **7.04 Timely and Accurate Recertification Required**

Recertification for each Waiver participant must be correctly done at least once in every 12-month period. Failure to submit all of the required forms and documents, correctly filled out, properly signed and on time is a reason for a fiscal disallowance. County agencies may lose Waiver funds for any claims made during a time period when the participant's eligibility was not properly established and documented. Counties must conduct recertification determinations by the end of the calendar month of the anniversary date or prior to the anniversary. If a county conducts the recertification determination early, this sets up a new anniversary date for future recertification determinations. Except for BI Waiver participants, the completion of the LOC Form or LTCFS, and the Eligibility and Cost-Sharing Worksheet or CARES forms need not occur in the same month.

### **7.05 Individual Service Plan Revisions**

Whenever the Waiver participant is expected to experience a change in the amount, frequency, intensity, type, or provider of a service the change must be documented in the participant's Individual Service Plan. The reason for the change must be documented in the participant's record. A copy of the Individual Service Plan showing the change in the service, unless previously anticipated and documented in the plan (e.g. the completion of a Home Modification project) must be sent to BDDS central office. All of the changes listed in this section must be approved by the Waiver participant/guardian, and the Support and Service Coordinator. These approvals must be documented on the participant's Individual Service Plan and must include a signature. The plan must be placed in the participant's file and available for review on request. Changes to plans are subject to BDDS approval.

The Individual Service Plan should continue to conform to the requirements in Chapter 6 of this Medicaid Waivers Manual and reflect all of the services to be provided to the individual to meet the Waiver participant's needs. It is possible that some services or service levels will vary during the year. The Individual Service Plan should be written to document such changes by reflecting the maximum number of units of services to be provided. For example, if a Waiver participant receives respite care at varying levels from month to month, the Individual Service Plan should indicate this variability and reflect the maximum level of services anticipated for a month and for the period covered by the ISP.

The Support and Service Coordinator should notify their assigned Community Integration Specialist (CIS) of the addition or deletion of a Waiver covered service. Any BDDS CIS concerns with the change will be expressed upon receipt of the updated Individual Service Plan.

BDDS must be notified within 30 days when a Waiver participant's address changes, when a change of guardian has been made or when a participant discontinues participation in the Waiver program. Failure to notify BDDS impedes BDDS' ability to provide required assurance to the federal authorities and could create problems for the state, county and participant.

### **7.06 Periodic Review of Assessments and Individual Service Plans**

To assure that the participant's Individual Service Plan continues to reflect his/her preferences, desired outcomes and meets his/her needs, the participant's assessment, Individual Service Plan and all reports required of the providers utilized for all services provided to the participant, must be reviewed. The participant's Support and Service Coordinator typically does these reviews. The person conducting the reviews should be someone who is not organizationally connected to a service provider (other than the service of support and service coordination- (see conflict of interest materials in Chapter IV)). These required reviews must occur at least once every six months. The review must be documented in the person's file both to document that this requirement was met and to justify any claims made for payment for the provision of this service.

The need for a revised assessment or Individual Service Plan depends on the results of each periodic review. If the previous assessment is still current and accurate and the plan is adequately supporting the person's life in the community, achieving the participant's desired outcomes and is meeting the participant's needs, no change to the assessment or Individual Service Plan is required. If there are changes to the participant's status, indications that needs are not being adequately addressed or indications that the participant's health and safety-related needs are not being adequately addressed, the assessment and Individual Service Plan must be updated accordingly.

The six-month review required by this section must also involve the participant, the participant's guardian and any other significant others involved in the participant's life such as involved family members. The participant's file must document that the participant and/or their guardian were involved in the review and that they agree that the services and supports provided in the Individual Service Plan continue to meet the participant's needs, facilitate the achievement of the participant's outcomes and reflect the participant's preferences. Whenever the participant or his/her guardian requests changes to be made to the Individual Service Plan, these requests should be clearly explained and documented in the person's file and should also include a description of how the Support and Service Coordinator responded to the request. If the request could not be addressed, the reasons must be explained and documented.